



## Autonomy and authority in medical futility

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Medical futility has been proposed for many years to define the procedure that simply prolongs the suffering of patients but heals nothing<sup>[1]</sup>. To deal with the decision procedure for treatment, two ideas arise: patients' autonomy and doctors' authority. Widely recognized in 1960s, patients' autonomy respected patients' willingness over treatment, requiring specific consent for treatment and right to choose during medical procedure. Another idea for futility is doctors' authority, explained from the paternalistic perspective as well<sup>[2]</sup>. Modern medicine, which is based on patients' autonomy and doctors' authority, should attain a balance in between.

The Physician Orders for Life Sustaining Treatment (POLST) form<sup>[3]</sup> in the USA offers patients choices for what treatments are acceptable and what should be avoided with complete awareness of their own conditions. As is not a simple transfer of guardianship or surrogation, its legal validity of protocol will ensure that a person's responsibility for the after-death decision-making and the reciprocal procedure to attain enough communication, which help to eclipse the concern about medical professionals' arbitrary decisions.

Decisions identifying the appropriate or inappropriate treatments should be based on a shared understanding of the prognosis, rather than patients or their family's emotional exhaustion and burnout. Especially in critically ill patients, 32% of surrogates, as a study has shown, would choose continued treatment for the patients despite being told of a less than 1% chance of

survival<sup>[4]</sup>. In that case, views supporting the decision "takes precedence over patients' autonomy and permits doctors to withhold or withdraw the care deemed to be inappropriate without subjecting such a decision to patients' approval"<sup>[5]</sup> become acceptable. The Texas Advanced Directives Act sets out an extrajudicial process of review involving hospitals' ethics committees. If doctors believe that providing treatment would be inappropriate for patients who are irreversibly ill, they may invoke the act and seek review from the ethics committee. If the committee agree with doctors, families are given 10 days to find another healthcare provider who is willing to provide treatment. Otherwise, treatment will be withdrawn<sup>[6]</sup>. Highlight for the bogus decision opposing the healing purpose incarnate the paternalistic perspective if the possibility of survival and improved life quality is medically acceptable.

Resuscitation in the intensive care unit (ICU) can be an example in the Queensland case that the Not-For-Resuscitation (NFR) Order without the consent of the family troubled the health care service, for the Guardianship and Administration Act 2000 (GAA) and the Powers of Attorney Act 1998 (PAA) clarified the consent for NFR order is principally needed<sup>[7]</sup>. Though explanation in this case supports that the medical intervention is dismal and that appropriate response is to assign doctor as an alternative surrogate to avoid futility<sup>[7]</sup>, more emergent scenario sparing no time or possibility of preliminary consensus or agreement should give in to doctors' decision, if proved to be

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medically feasible. But medical ethics has already defined that any medical decision without the knowledge of family or surrogates is ethically unacceptable<sup>[8]</sup>, which means an intermediary role to smooth the risk of doctors is requisite during futility decision.

Another example is clinical trials as an approach in clinical practice. Patients' autonomy being incomplete in clinical trials has been argued substantially about in which the legal capacity and psychological capacity is hard to define clearly and doctors' therapeutic expectations can subjectively decide the competence of patients. The decision-making as "an inherently individualized process"<sup>[9]</sup> should be alerted because considering vague prediction, the term itself can be defined as a kind of "futility". Additionally, legislative models for notification of the medical condition and the decision-making isolated from coercive or induced efforts should be established in the future.

To conclude, proper tendency for autonomy or authority based on actual situations and national medical conditions should be an advocated measure to deal with futility. Ethical consideration led by emphasis on autonomy is predominant in clinical

practice, and the final say in medical futility should emphasize on ceasing futile intervention.

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